

Improving Coordination and Access to Comprehensive School- Based Mental Health Services in California

A Preliminary Landscape Analysis

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March 2022

Suggested citation: Romer, N., Valdez, A., Alcalá, L., Diaz, J., Gurrola, E., McClellan, P., & McCullough, S. (2022). *Improving coordination and access to comprehensive school-based mental health services in California: A preliminary landscape analysis*. WestEd.

The content of this report was developed under a grant from the U.S. Department of Education through the Office of Program and Grantee Support Services (PGSS) within the Office of Elementary and Secondary Education (OESE) by the Region 15 Comprehensive Center at WestEd under Award #S283B190053. This contains resources that are provided for the reader's convenience. These materials may contain the views and recommendations of various subject matter experts as well as hypertext links, contact addresses, and websites to information created and maintained by other public and private organizations. The U.S. Department of Education does not control or guarantee the accuracy, relevance, timeliness, or completeness of any outside information included in these materials. The views expressed herein do not necessarily represent the positions or policies of the U.S. Department of Education. No official endorsement by the U.S. Department of Education of any product, commodity, service, enterprise, curriculum, or program of instruction mentioned in this document is intended or should be inferred.



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Acknowledgments

The Regional Educational Laboratory West at WestEd provided technical assistance and support to the California Department of Education and the California State Board of Education on the data and descriptive analyses included in this report.

We would like to thank Michael Ishimoto and Nedim Yel for their collaboration and valuable guidance throughout this project. We also appreciate the insightful review of our report by Kenwyn Derby, Thomas Hanson, Heather Mattson, and Christina Pate.



Executive Summary

Despite the national attention that [mental health and well-being](#) have received amid the ongoing pandemic, school communities face multiple challenges in providing students, families, and educators with necessary supports and services, particularly the following:

- the increased need for mental health services and supports
- stigma and misconceptions regarding mental health services
- lack of access to culturally relevant or appropriate mental health services
- school- and community-based behavioral and mental health staffing shortages
- limited capacity to support implementation of comprehensive school-based mental health systems

California faces an unprecedented opportunity to expand school-based mental health care. The 2021–22 California budget includes nearly \$4 billion to support child and youth behavioral health and nearly \$3 billion to support community schools.¹ Understanding the current strengths, barriers, and opportunities of school-based mental health referral pathways is key to making informed decisions about how resources should be allocated and how technical assistance should be designed to effectively support mental health services for students. The Region 15 Comprehensive Center (R15 CC) and the Regional Educational Laboratory West (REL West), both housed at WestEd, collaborated with the California Department of Education (CDE) and the California State Board of Education (SBE) to conduct an initial landscape analysis to understand the current state of school-based mental health referral pathways in California. School-based mental health referral pathways provide the infrastructure (processes, resources, and procedures) for identifying, referring, and monitoring whether students, families, and educators are linked to appropriate mental health services within a network of school and community partners.² This landscape analysis is based on (a) quantitative, descriptive analyses to explore factors such as student demographics, school climate survey data, and staffing ratios; (b) interviews with district, county, and state leaders on the current state of school-

¹ California State Budget 2021–22 Summary, K–12 Education.

<https://www.ebudget.ca.gov/2021-22/pdf/Enacted/BudgetSummary/K-12Education.pdf>;

California State Budget 2021–22, Summary Health and Human Services.

<https://www.ebudget.ca.gov/2021-22/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf>

² Substance Abuse and Mental Health Services Administration. (2015). *School mental health referral pathways toolkit*. <http://files.ctctcdn.com/bde05f96001/84fa3636-08af-43fc-aeaf-a016f2aa68a6.pdf>



based mental health referral pathways in California; and (c) a document scan of existing research, tools, and guidance on referral pathways. These analyses explored the following:

- variations in the numbers of school-based mental health service staff per student by geographic region, county, district enrollment, student demographics, and student mental health outcomes
- how schools are implementing comprehensive mental health service systems focused on the whole person
- how educational agencies are partnering with behavioral health and other youth-serving agencies and organizations to provide students with mental health services and supports
- what current mental health referral pathways look like within California schools and between schools and partnering community agencies
- what policies and resources support school-based mental health referral pathways in California

The following findings emerged from the analyses:

- **Finding 1.** Students in California had significant mental health and related support needs prior to the pandemic that have only further increased.
- **Finding 2.** Despite growing student mental health needs, critical school and community behavioral and mental health staffing shortages persist.
- **Finding 3.** School-based mental health referral pathways are not always aligned and coherent, and approaches to service delivery vary greatly across the state.
- **Finding 4.** Limited funding flexibility and varied understanding of how to navigate, maximize, and plan for sustainability of available funding sources constitute a key barrier to expanding access to mental health services for students.
- **Finding 5.** A limited understanding of complex privacy laws and regulations by educational leaders and community partners can be a barrier to providing school-based mental health services.

The following strategies emerged as considerations for improving school-based mental health referral pathways in California:

- **Consideration 1.** Invest in diversifying, recruiting, training, and retaining a behavioral and mental health workforce that is representative of California's linguistically and culturally diverse population.



- **Consideration 2.** Provide ongoing cross-agency technical assistance and support for education and mental health partner agencies focused on building capacity and supporting the continuous improvement of comprehensive and cohesive, multi-tiered school-based mental health service delivery systems that are codesigned with students and families.
- **Consideration 3.** Create structures that support more sustainable, straightforward use of funds to expand and continuously improve comprehensive school-based mental health systems.
- **Consideration 4.** Support the development of tools and training for local educational agencies (LEAs) and partner organizations on appropriate cross-agency information sharing related to student mental health services and supports; this information sharing should prioritize student and family privacy.



Introduction

Positive mental health is linked to a number of successful outcomes for youth and adults, including the ability to thrive socially and emotionally as well as cope with the stresses of life. A whole-person approach to support mental health and well-being considers individual, family, community, and population factors that can promote health or increase harm.³ **Comprehensive mental health systems actively eliminate systemic barriers to positive mental health and increase health equity by ensuring all students and staff have access to a full continuum (e.g., Multi-Tiered System of Supports [MTSS]) of culturally responsive interventions, starting with a safe, supportive, and affirming school climate.**⁴ This public health approach has been particularly useful in supporting the mental health needs of young people and can in turn reduce the need for long-term services or support.⁵ Conversely, when left untreated, behavioral, social, and emotional problems often become worse, resulting in a myriad of negative personal and societal outcomes, including difficulties in school, substance abuse, employment difficulties, violence, and suicide.

Even before the COVID-19 pandemic, there was a clear need to support youth through comprehensive mental health services. Researchers estimated that approximately one in five youth in the United States experienced a diagnosable mental health challenge, while most did not access therapeutic services.⁶ Since the start of the COVID-19 pandemic, the prevalence of mental illness in children and adolescents has increased—particularly depression and anxiety—while access to mental health services and school-based supports has been limited.⁷ The

³ O'Connell, M. E., Boat, T. F., & Warner, K. E. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Academies Press; Weist, M. D., Lever, N. A., Bradshaw, C. P., & Owens, J. S. (Eds.). (2014). *Handbook of school mental health: Research, training, practice, and policy* (2nd ed.). Springer.

⁴ Malone, C. M., Wycoff, K., & Turner, E. A. (2021). Applying a MTSS framework to address racism and promote mental health for racial/ethnic minoritized youth. *Psychology in the Schools*.
<https://doi.org/10.1002/pits.22606>

⁵ Bierman, K. L., Mathis, E. T., & Domitrovich, C. E. (2018). Serving the needs of young children with social, emotional, and behavioral needs: A commentary. *School Mental Health, 10*, 254–263.
<https://doi.org/10.1007/s12310-018-9265-4>

⁶ Merikangas, K. R., He, J.-ping, Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(10), 980–989. <https://doi.org/10.1016/j.jaac.2010.05.017>

⁷ Golberstein, E., Wen, H., & Miller, B. F. (2020). Coronavirus disease 2019 (COVID-19) and mental health for children and adolescents. *JAMA Pediatrics, 174*(9), 819–820.
<https://doi.org/10.1001/jamapediatrics.2020.1456>; Racine, N., Cooke, J. E., Eirich, R., Korczak, D. J., McArthur, B., & Madigan, S. (2020). Child and adolescent mental illness during COVID-19: A rapid review. *Psychiatry Research, 292*, 113307. <https://doi.org/10.1016/j.psychres.2020.113307>; Singh, S., Roy, D., Sinha,



current mental health crisis is impacting school communities across the country that had been struggling to meet the unfilled mental health needs of students and their families prior to the pandemic, often without the requisite systems to ensure coordinated, effective, and comprehensive service delivery.⁸

Despite the national attention that mental health and well-being have received amid the ongoing pandemic—including Congress providing significant federal funding to support mental health—school communities face multiple challenges in providing youth with necessary supports and services. Traditionally, behavioral health care has been provided within clinics to address a diagnosable problem outside of the school setting, which presents significant barriers for students and their families. Even in communities with school-based mental health practitioners, budget restrictions and billing requirements often result in staff traveling between schools, which can limit student access and the ability of practitioners to become embedded in the school environment and support a comprehensive school mental health system.⁹ Further, for many youth, negative public or cultural perceptions of mental health challenges can act as a barrier, even in cases where services are available.¹⁰ In a recent survey of principals in California, one in four (26%) reported language and cultural barriers to mental health service delivery.¹¹ Common barriers (reported by over 50% of principals) included insufficient funding, access issues related to distance learning, and a lack of school- and community-based providers. Additional barriers to the delivery of mental health services also included competing demands and priorities, parental cooperation and consent, and the stigma associated with mental health services.

The challenges in providing comprehensive mental health services are particularly amplified for children and adolescents from historically marginalized and underserved groups. For example, children living in poverty are more likely to experience mental health challenges,¹² and

K., Parveen, S., Sharma, G., & Joshi, G. (2020). Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations. *Psychiatry Research*, 113429. <https://doi.org/10.1016/j.psychres.2020.113429>

⁸ Farmer, E. M., & Farmer, T. W. (1999). The role of schools in outcomes for youth: Implications for children's mental health services research. *Journal of Child and Family Studies*, 8(4), 377–396; Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology review*, 3, 223–241. <https://doi.org/10.1023/A:1026425104386>

⁹ Barrett, S., Eber, L., & Weist, M. D. (2013). *Advancing education effectiveness: An interconnected systems framework for Positive Behavioral Interventions and Supports (PBIS) and school mental health*. Center for Positive Behavioral Interventions and Supports . University of Oregon Press.

¹⁰ Seeman, N., Tang, S., Brown, A. D., & Ing, A. (2016). World survey of mental illness stigma. *Journal of Affective Disorders*, 190, 115–121. <https://doi.org/10.1016/j.jad.2015.10.011>

¹¹ Saphir, M., Geierstanger, S., & Soleimanpour, S. (2021). *California Department of Education Project Cal-Well: 2020–21 Statewide Principals Survey summary report*. University of California, San Francisco.

¹² Barnes, A. J., Gilbertson, J., & Chatterjee, D. (2018). Emotional health among youth Experiencing Family Homelessness. *Pediatrics*, 141(1). <https://doi.org/10.1542/peds.2017-1767>



receiving services outside of the school setting can be extremely difficult without access to reliable transportation or when services are provided outside of school hours. Similarly, newcomer youth or youth identifying as LGBTQI+ are at an elevated social–emotional risk, and privacy concerns related to their immigration status or identity may discourage them from seeking help.¹³

Systemic racism also has an impact on mental health. Youth of color often have higher rates of suicide or suicidal thoughts than their White peers.¹⁴ Often the mental health services and support systems that are available to youth of color are not culturally relevant to them, as many evidence-based practices and programs were developed and are implemented from a White perspective. Like other marginalized groups, youth of color may not be encouraged to seek or access mental health supports, frequently leaving them with unmet mental health needs. Far too often, these unmet and misunderstood needs lead to exclusionary discipline, such as suspension or expulsion, and loss of learning time. Cultural awareness and competence, along with culturally appropriate clinical skills, can greatly improve outcomes for youth of color. Moreover, services and supports are accessed within larger systems and directly impacted by systemic and contextual factors. The coordination of improved and equitable access to mental health services for students, families, and educators requires implementation structures to support a continuum of culturally sustainable practices that promote well-being and build on the values, strengths, and assets of the school community to create meaningful learning experiences that are representative of the voices and lived experiences of a school community.¹⁵

California recognizes the importance of collaborative and comprehensive school-based mental health service delivery and the role of school communities in supporting whole-person models along with implementation frameworks that align with best practices and rely on state leadership, funding, and capacity building.¹⁶ Whole-person approaches to service delivery realize that students and their families are not just seeking a continuum of interventions that

¹³ Gonzales, G., de Mola, E. L., Gavulic, K. A., McKay, T., & Purcell, C. (2020). Mental health needs among lesbian, gay, bisexual, and transgender college students during the COVID-19 pandemic. *Journal of Adolescent Health*, 67(5), 645–648. <https://doi.org/10.1016/j.jadohealth.2020.08.006>

¹⁴ Price, J. H., & Khubchandani, J. (2019). The changing characteristics of African-American adolescent suicides, 2001–2017. *Journal of Community Health*, 44, 756–763. <https://doi.org/10.1007/s10900-019-00678-x>

¹⁵ Jackson, R. G., Coomer, M. N., Sanborn, E., Dagli, C., Martinez Hoy, Z. R., Skelton, S. M., & Thorius, K. A. K. (2018). Teaching towards understandings of intersectionality. *Equity Dispatch*. Midwest & Plains Equity Assistance Center (MAP EAC).

¹⁶ Stephan, S. H., Sugai, G., Lever, N., & Connors, E. (2015). Strategies for integrating mental health into schools via a multitiered system of support. *Child and Adolescent Psychiatric Clinics of North America*, 24(2), 211–231. <https://doi.org/10.1016/j.chc.2014.12.002>; Weist, M. D., Eber, L., Horner, R., Splett, J., Putnam, R., Barrett, S., Perales, K., Fairchild, A. J., & Hoover, S. (2018). Improving multitiered systems of support for students with “internalizing” emotional/behavioral problems. *Journal of Positive Behavior Interventions*, 20(3), 172–184. <https://doi.org/10.1177/1098300717753832>



reduce levels of mental illness and social–emotional difficulties but also approaches and interventions that foster overall well-being and opportunities to fully engage in academic and social experiences.¹⁷

In a recently released report, [Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs](#), the U.S. Department of Education recommended the following: (a) prioritize wellness for each and every child, student, educator, and provider; (b) enhance mental health literacy and reduce stigma and other barriers to access; (c) implement a continuum of evidence-based prevention practices; (d) establish an integrated framework of educational, social, emotional, and behavioral health support for all; (e) leverage policy and funding; (f) enhance workforce capacity; and (g) use data for decision making to promote equitable implementation and outcomes.¹⁸

The [ecosystem](#) informing comprehensive mental health service delivery is complex and spans what have historically been largely siloed health and education systems. Thus, the development of comprehensive, coordinated mental health services requires alignment of community-driven practices, policies, and resources at all levels of the service delivery system.¹⁹

¹⁷ Biglan, A., Flay, B. R., Embry, D. D., & Sandler, I. N. (2012). The critical role of nurturing environments for promoting human well-being. *American Psychologist*, 67(4), 257–271. <https://doi.org/10.1037/a0026796>; Doll, B., Lazurus, P., & Suldo, S. M. (2021). *Fostering the emotional well-being of our youth: A school-based approach*. Oxford University Press.

¹⁸ U.S. Department of Education, Office of Special Education and Rehabilitative Services. (2021). *Supporting child and student social, emotional, behavioral, and mental health needs*. <https://www2.ed.gov/documents/students/supporting-child-student-social-emotional-behavioral-mental-health.pdf>

¹⁹ Hoover, S., Lever, N., Sachdev, N., Bravo, N., Schlitt, J., Acosta Price, O., Sheriff, L., & Cashman, J. (2019). *Advancing comprehensive school mental health: Guidance from the field*. National Center for School Mental Health. University of Maryland School of Medicine.



Effective partnerships between school districts, communities, and county agencies increase access to mental health services for students and families by providing a continuum of school-based mental health and wellness interventions. Strong partnerships between school and community behavioral and mental health systems are essential for maximizing resources to meet the mental health needs of school communities. Unfortunately, California continues to experience [critical shortages](#) of key school-based mental health professionals (e.g., school social workers, nurses, counselors, psychologists) integral to serving school communities. Furthermore, there are gaps in the behavioral health workforce, with substantial variability in ratios across regions of the state and a lack of diversity aligned with the state's demographic composition.²⁰ School and community behavioral and mental health staff not only provide behavioral and mental health services but serve on multidisciplinary leadership teams that oversee the continuous improvement of a school community's comprehensive mental health service system. Within that system, **school-based mental health referral pathways provide the infrastructure (processes, resources, and procedures) for identifying, referring, and monitoring whether students, families, and educators are linked to appropriate mental health services within a network of school and community partners.**²¹

Referral pathways are how students, families, and educators can effectively access mental health services and supports. They require a robust infrastructure, including policy, funding, and technical assistance, to support the development and continuous improvement of a comprehensive and equitable mental health system. When implemented within a comprehensive school mental health system, effective referral pathways have the following features:

- multidisciplinary leadership teams that collaboratively implement a comprehensive mental health system and have a shared understanding of how individual and systemic bias, culture, and power influence decisions
- MTSS structures such as problem-solving, data-based decision-making, and progress monitoring
- collaborative decision-making that prioritizes what is best for the family

²⁰ Coffman, J., Bates, T., Geyn, I., & Spetz, J. (2018). *California's current and future behavioral health workforce*. <https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California%E2%80%99s%20Current%20and%20Future%20Behavioral%20Health%20Workforce.pdf>

²¹ Substance Abuse and Mental Health Services Administration. (2015). *School mental health referral pathways toolkit*. <http://files.ctctcdn.com/bde05f96001/84fa3636-08af-43fc-aeaf-a016f2aa68a6.pdf>; Wisconsin Department of Public Instruction. (2019). *School mental health referral pathways guide*. https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/DPI_Mental_health_referral_pathways_web.pdf



- multiple data sources, methods, and measures to identify the strengths and needs of students, families, and educators
- objective and systematic gathering and analyzing of information in ways that promote equity and inform planning to support the whole person
- internal referral processes within the school's continuum of mental health interventions and external referral processes to community organizations and resources
- monitoring of the effectiveness and implementation of practices and interventions provided by all partners
- clearly articulated procedures for managing referrals between partners, including warm handoffs, ongoing communication, and transition planning
- established systems and procedures for sharing information and communication, including adherence to the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), tracking referrals, and progress monitoring

(Adapted from Substance Abuse and Mental Health Services Administration [SAMHSA], 2015)²²

Referral pathways center students and their families at every step within the process and consider systemic, developmental, cultural, and linguistic factors impacting how the comprehensive mental health service system provides supports and services across the continuum. Multidisciplinary leadership teams carefully consider the limitations of traditional data sources (e.g., office discipline referrals) and methods (teacher referrals) of identifying student needs and implement practices in initial identification of students that can mitigate these biases and promote equitable access to supports (e.g., universal mental health awareness, mental health literacy training, universal mental health screening processes, strengths-based approaches to data-based decision-making).²³

²² Substance Abuse and Mental Health Services Administration. (2015). *School mental health referral pathways toolkit*. <http://files.ctctcdn.com/bde05f96001/84fa3636-08af-43fc-aeaf-a016f2aa68a6.pdf>

²³ Wisconsin Department of Public Instruction. (2021). *The Wisconsin school mental health framework: Building and sustaining a comprehensive system*. https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/Wisconsin_School_Mental_Health_Framework_-_Building_and_Sustaining_a_Comprehensive_System.pdf



Present Landscape Analysis

California is experiencing an unprecedented opportunity to allocate significant resources to expand comprehensive school-based mental health supports for students, families, and educators. The 2021–22 California budget includes nearly \$4 billion to support child and youth behavioral health and nearly \$3 billion to support community schools).²⁴ As California’s schools offer in-person learning in the 2021–22 school year, the California Department of Education and the State Board of Education are interested in helping schools and districts consider how to support the increasing and disparate mental health needs of students since the start of the COVID-19 pandemic.

Understanding the current strengths, barriers, and opportunities of school-based mental health referral pathways is key to making informed decisions about how resources should be allocated and how technical assistance should be designed to effectively support comprehensive school-based mental health systems. The Region 15 Comprehensive Center (R15 CC) and the Regional Educational Laboratory West (REL West) at WestEd collaborated with the California Department of Education (CDE) and the California State Board of Education (SBE) to conduct an initial landscape analysis to understand the current state of school-based mental health referral pathways in California. In the sections of the report that follow, the group of representatives from each of these entities is referred to as the *research team*. The study involved (a) quantitative, descriptive analyses to explore factors such as county, LEA geographic areas, student demographics, staffing, and school climate survey data; (b) qualitative interviews with a small sampling of district, county, and state leaders on the current state of school-based mental health referral pathways, as well as the systems, partnerships, funding, and policies that inform how effective mental health services are accessed in California; and (c) a document scan of available reports and tools related to referral pathways.

As a first step in exploring the current state of school-based mental health referral pathways and the school mental health support systems in which they function, the research team sought to answer the following questions:

- **Student Mental Health Outcomes.** What are the primary mental health (or related) strengths and needs of California’s students?

²⁴ California State Budget 2021–22 Summary, K–12 Education.

<https://www.ebudget.ca.gov/2021-22/pdf/Enacted/BudgetSummary/K-12Education.pdf>;

California State Budget 2021–22, Summary Health and Human Services.

<https://www.ebudget.ca.gov/2021-22/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf>



- **School-Based Mental Health Workforce Capacity.** How does the number of school-based mental health service staff per student vary by geographic region, county, and school district? How does the number of school-based mental health service staff per student vary by LEA enrollment size and student demographics?
- **Comprehensive Mental Health Service Systems.** How are LEAs implementing comprehensive mental health service systems focused on the whole person? How are LEAs implementing coordinated service delivery within schools and with community partners?
- **Partnerships for School-Based Mental Health.** How are educational agencies partnering with behavioral health and other youth-serving agencies and organizations, including substance abuse recovery programs, to meet the mental health needs of children, adolescents, families, and educators?
- **Types of School-Based Mental Health Referral Pathways.** What do current referral pathways look like within California schools and between schools and partnering community agencies and organizations?
- **Policies and Resources That Support School-Based Mental Health Referral Pathways.** What policies and resources support school-based mental health referral pathways in California?



Methods

Quantitative Data Analysis

REL West, the CDE, and the SBE engaged in a collaborative analysis project to better understand the extent to which school-based mental health service staff are available to address student mental health needs across the state. The research team examined staffing and student survey data at the LEA level to better understand school-based mental health service staffing patterns across the state and the variation in self-reported student mental health issues. A better understanding of these patterns will help inform the CDE/SBE about where school-based support may not sufficiently meet student needs. With this information, the CDE can provide guidance and support for local policies and practices that increase the number of school-based mental health service staff where they are needed most. The research team identified four questions to guide their analysis:

- How do self-reported student mental health outcomes vary by county?
- How do self-reported student mental health outcomes vary by LEA enrollment size and student demographics?
- How does the number of school-based mental health service staff per student vary by county?
- How does the number of school-based mental health service staff per student vary by LEA enrollment size and student demographics?

The research team reviewed quantitative data from three data sources: (a) the California Healthy Kids Survey (CHKS),²⁵ (b) the California State Geoportal,²⁶ and (c) the CDE Dataquest site.²⁷

School Climate Data. The research team used CHKS data from the 2018–19 school year from 440 LEAs. These are student-level, de-identified survey data containing information on self-reported student mental health issues, including thoughts about self-harm; bullying incidents;

²⁵ California Department of Education. (2021). *California Healthy Kids Survey*. Obtained through submission of a data sharing agreement with the CDE.

²⁶ California Department of Education. (2020). *California school district areas 2018-19*.
<https://gis.data.ca.gov/datasets/CDEGIS::california-school-district-areas-2018-19/explore?location=37.246158%2C-119.002219%2C6.81&showTable=true>

²⁷ California Department of Education Data Reporting Office. (2021). *2018-19 number of pupil services staff by type*. Retrieved December 15, 2021, from <https://dq.cde.ca.gov/dataquest/PuplSvs2.asp?cYear=2018-19&cChoice=CoPupSvcs1&cCounty=01,ALAMEDA>



and use of alcohol, tobacco, and other drugs. For this initial analysis, the research team prioritized indicators of psychological distress associated with mental illness and substance abuse. A complete list of CHKS variables analyzed in this report is provided in Appendix A. The data were aggregated to the LEA level. The CHKS survey is voluntary and is not representative of the whole state. A preliminary analysis of these data indicated that on average, nine LEAs per county were represented in the data, or roughly 50 percent of all LEAs in the county.²⁸ Ten counties²⁹ had no LEAs represented in the CHKS data from the 2018–19 school year. Of the LEAs not represented in the CHKS data, over 80 percent were LEAs in Shasta County, Siskiyou County, or San Benito County.

Student Demographic Data. The demographic data from the California State Geoportal website included LEA-level student demographics from the 2018–19 school year from 944 LEAs in the state. The data included the percentage of students in each race/ethnic category and the percentage of students with individual education plans (IEPs) or who are classified as English Learners, are in foster care, are homeless, or are migratory.

School-Based Mental Health Service Staff Data. School-based mental health service staff data from 839 LEAs from the 2018–19 school year were obtained on the CDE Dataquest website. These data indicate the number of school-based mental health service staff who work in each district by type, including school nurses, school counselors, school psychologists, and school social workers. Given that statewide data on mental health referrals or services to students are not available, the research team determined that staffing data would be the best available data to examine LEA capacity for providing mental health services. These staff play an important role in supporting the mental health and well-being of students and the school community.³⁰ Shortages of these professionals, who bring the unique combination of expertise in mental health and education, have the potential to undermine the availability of high-quality services to students, families, and schools.³¹

These data have several limitations. Staffing data only speak to the quantity of staff in an LEA, not the quality of services. Further, CHKS surveys are voluntary student surveys. The majority of

²⁸ The number of total LEAs in each county is obtained from the California State Geoportal.

²⁹ The 10 counties are Colusa, Del Norte, Mariposa, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, and Siskiyou Counties.

³⁰ American School Counselor Association. (2021). *The role of the school counselor* [Role statement]. <https://www.schoolcounselor.org/getmedia/ee8b2e1b-d021-4575-982c-c84402cb2cd2/Role-Statement.pdf>;
National Association of Social Workers. (2012). *NASW standards for school social work services*. <https://www.socialworkers.org/LinkClick.aspx?fileticket=5qpx4B6Csr0=&portalid=0>

³¹ National Association of School Psychologists. (2021). *Policies addressing the shortage of school psychologists*. <https://www.nasponline.org/research-and-policy/policy-priorities/critical-policy-issues/shortage-of-school-psychologists>



responses were from students in urban LEAs with larger student enrollment sizes. Accordingly, the results may be skewed toward larger, more urban LEAs.

Interviews

Through a series of 1-hour virtual structured interviews conducted between November 15 and December 3, 2021, the research team elicited feedback from LEA administrators, behavioral health organization leaders, and content experts. The interview protocol was developed by first building out the different content categories that could be associated with each content domain, then creating questions to understand each content category as its own separate module. The school district protocol was then adapted for interviewees from behavioral health organizations and consultants/advocates. To review a complete protocol, see Appendix B.

Interviewees were selected based on the following criteria:

- **Geography.** Interviewees were selected to represent the northern (N = 2), Bay Area (N=2), central (N = 1), and southern (N = 2) regions of California. Interviewees also represented urban, rural, and remote regions across the state.
- **Student Demographics.** Regions were also selected to represent a diversity of student demographics, including race and ethnicity; multilingual learners; and the number of students who are economically disadvantaged, are in foster care, are experiencing unstable housing, and/or are migratory.
- **Promising Practice or Exemplary Service.** Interviewees were considered based upon notable, innovative, or distinguished work in a particular region as identified by internal content experts and existing research.
- **Agency Type.** Interviewees were selected to represent a range of agencies and organizations involved in school-based mental health, including school districts (N = 4), county offices of education (N = 1), departments of education (N = 2), county behavioral health departments (N = 3), and service provider organizations (N = 2) as well as nonprofits and policy and advocacy organizations (N = 4).

Outreach was conducted via email sent by R15 CC staff. In the invitation email, all prospective interviewees received a brief introduction to the study, including an explicit assurance of confidentiality, as well as a Doodle Poll link with available time slots for their participation. Each interview was conducted by an interviewer, who asked questions and moderated discussion as needed, and a transcriber, who transcribed interviewee responses for the purpose of collecting qualitative data to be analyzed at a later date. The final sample included 14 interviews with 16 recruited interviewees for an 88 percent participation rate.



Document Scan

The R15 CC team conducted a high-level document scan of existing research, tools, and guidance on school-based mental health referral pathways. Appendix C includes a refined list of comprehensive resources.



Analyses

The **quantitative analysis** of this report is a descriptive analysis, outlining the variation in student mental health indicators and school-based mental health service staff across the state. The research team sought to describe this variation in the most straightforward way possible.

First, they focused on processing student demographic, enrollment, and pupil services staff data. Because each of these datasets is produced by the CDE, the research team was able to merge these sources using CDE-issued identification numbers to create a single dataset with both student and staff data. From this merged dataset, the research team calculated the number of students per mental health service staff; for example, 3,000 students divided by 30 nurses would equal 100 students per nurse. This calculation was performed for each of the four staff types, and the resulting student-to-staff ratios are at the center of each descriptive analysis. In addition, the research team examined total mental health staff head counts, aggregating each of the four staff types together into one head count to reflect mental health supports available to students. The final component of the analytic dataset is the set of student mental health indicators within the CHKS dataset, which were aggregated to the LEA level and merged to the previously mentioned dataset containing student and staff data.

Once the analytic dataset was created, the research team was able to examine the variables of interest (e.g., number of students per nurse, percentage of students who agree with the statement “I feel safe at school”) through descriptive analyses. To examine variation in a variable of interest across the state, the research team created a series of county-level heatmaps displaying the county average of that variable of interest. In these figures, each county is shaded according to how high or low the variable of interest is in that county relative to other counties. For example, counties where there are more students per nurse are shaded darker than counties with fewer students per nurse. Unless otherwise noted, each of the tables and figures produced for the quantitative analysis are populated with enrollment-weighted average mental health indicators and/or student-to-staff ratios by county. By calculating weighted averages rather than unweighted averages, the research team arrived at county-level averages which would more accurately reflect the average LEA in that county.³²

The **qualitative analysis** was conducted upon completion of all 14 interviews by the R15 CC team. Transcriptions of interviews were consolidated into one qualitative dataset. To analyze the dataset, the research team employed a technique that classifies the sign-vehicles (a

³² Specifically, LEAs with smaller enrollment sizes contribute slightly less to the calculation of the weighted average, while LEAs with larger enrollment sizes contribute slightly more. This way, very small LEAs do not disproportionately impact the county-level average.

meaningful word or set of words) into distinct categories or themes by an analyst or group of analysts.³³ For the purposes of the present study, multiple analysts, some of whom participated in the administration of the focus groups and some who did not, conducted the content analysis of qualitative data , to ensure reliability of themes and grouping of responses into distinct categories.

³³ Stewart, D. W., Shamdasani, P. N., & Rook, D. W. (2007). *Focus groups: Theory and practice*. SAGE Publications.

Key Findings

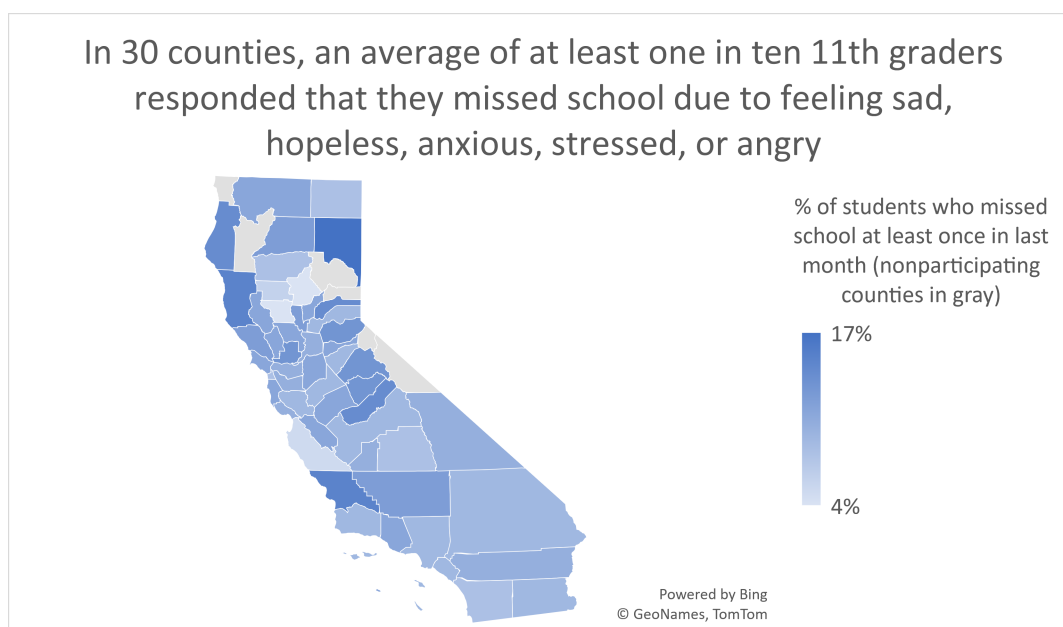
Finding 1. Students in California had significant mental health and related support needs prior to the pandemic that have only further increased.

Findings from interviews and quantitative analyses reflect trends across the country on mental health challenges prior to the pandemic. Interviewees discussed the intensifying mental health crisis and compounding impact of COVID-19 on the health and well-being of students, families, and educators.

Self-reported student mental health indicators varied by county.

Between 4 percent and 17 percent of 11th grade students in counties across the state reported having missed school in the last 30 days due to feeling sad, hopeless, anxious, stressed, or angry. In 30 counties, an average of at least one in ten 11th grade students cited those reasons for missing school in the last 30 days (see Figure 1).

Figure 1. Percent of 11th Grade Students Responding That They Missed a Day of School Due in the Last Month to Feeling Sad, Hopeless, Anxious, Stressed, or Angry by County



Note: Average across 2017 and 2019 CHKS survey years



Student responses to the self-reported student mental health indicators varied across the state. There was no discernable pattern with regard to LEA enrollment size or any student demographic. However, all five counties with the largest percentages of students having missed school in the last 30 days due to these feelings had slightly smaller LEAs, and four of these five counties had fewer students of color, than the statewide average (see Table 1).



Table 1. Selected Information for Counties With the Five Highest Percentages of 11th Grade Students Responding That They Missed a Day of School in the Last Month Due to Feeling Sad, Hopeless, Anxious, Stressed, or Angry³⁴

County	Total % reported missing for this reason	% Black students	% Hispanic/Latinx students	% White students	% Unduplicated pupils	Average LEA enrollment
Lassen County	17.2	1.5	17.4	68.4	23.9	384
Mendocino County	14.8	0.7	43.6	42.3	69.5	1,088
San Luis Obispo County	14.8	0.9	40.0	51.3	45.2	3,414
Madera County	14.5	1.5	74.8	19.4	76.1	3,463
Humboldt County	13.8	1.2	18.9	56.8	53.8	557
Statewide Average	11	5.4	54.6	22.8	63.7	6,425

Note: The statewide average row comes from Austin, G., Hanson, T., Zhang, G., & Zheng, C. (2020). *School climate and student engagement and well-being in California, 2017/19: Results of the Seventeenth Biennial State California Healthy Kids Survey, Grades 7, 9, and 11*. WestEd. https://data.calschls.org/resources/Biennial_State_1719.pdf.

Each interviewee attested to unprecedented levels of need.

In addition to what interviewees observed as broad increases in anxiety, depression, suicidality, and violence, interviewees noted the difficulty of identifying student mental health needs throughout the pandemic, as staff were not physically present with students, making it harder to observe behaviors and peer interactions that often highlight mental health challenges. The interviews also highlighted that returning to school after months of distance learning caused a marked loss of stability for many students. While the mental health needs of returning students are not necessarily new, they are more intense and common. At the same time, there is a persistent push, with learning loss at the forefront, for staff and students to bounce back quickly without allowing for time to heal. Schools are trying to implement and prioritize universal supports (e.g., social-emotional learning, trauma-informed approaches) while managing competing demands with limited resources.

³⁴ Average across 2017 and 2019 CHKS survey years.



Throughout the state, interviewees described the ways in which mental health and school staff have pivoted to providing basic necessities, such as food and rental assistance, since the start of the pandemic while attempting to provide ongoing mental health services. These challenges, while new to some areas of the state, were often increased for students of color and those in rural areas, who were already experiencing difficulty accessing care. In many cases, there are very few clinicians who match the linguistic and cultural diversity of students and their families.

Tsunami is a word frequently used to describe the amount of emotional trauma, adjustment issues for children who have been isolated and oftentimes behind, as well as youth who are simply not showing up, suicide rates are exploding. ... It feels like at every level there are high needs like we've never seen before.

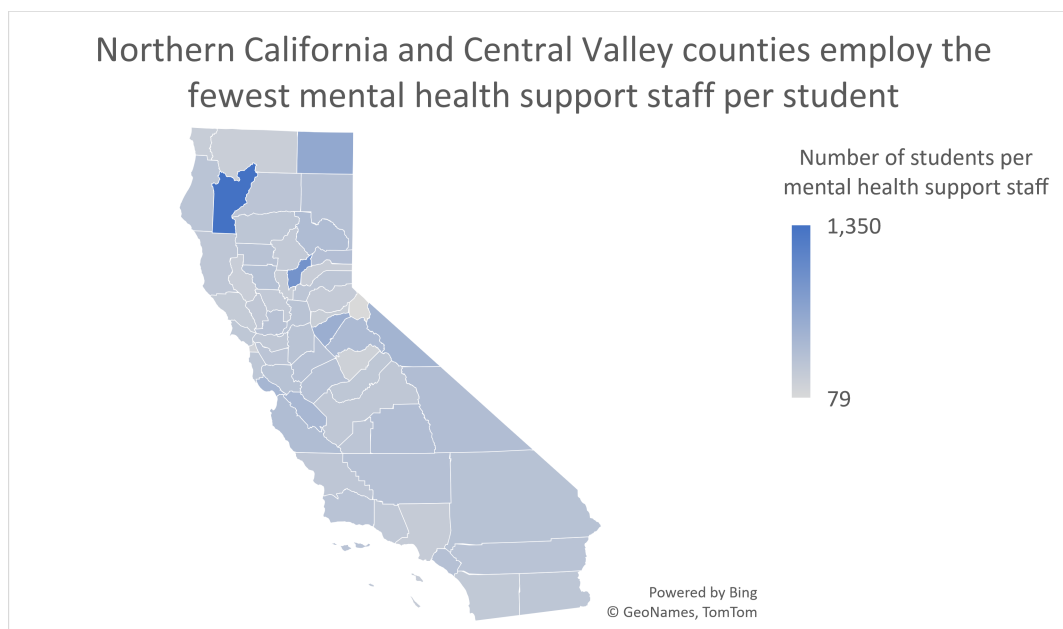
Interviewee

Finding 2. Despite growing student mental health needs, critical school and community behavioral and mental health staffing shortages persist.

The number of mental health staff of any type per student ranged from 79 to 1,350 across counties.

The counties that comprise the Central Valley and the northeast part of the state tended to be more understaffed than other counties. Student-to-total-mental-health-staff ratios were highest in Trinity County, Yuba County, and Modoc County (see Figure 2).

Figure 2. Number of Students Per Mental Health Support Staff by County, 2018–19 School Year



Across the state, mental health staffing is below the ratios recommended by professional organizations.

In seven counties, there are no psychologists or nurses in schools. The average number of students per psychologist was more than double the recommended ratio per the National Association of School Psychologists (NASP).³⁵ The number of students per counselor was nearly four times that of the recommended ratio according to the American School Counselor Association (ASCA).³⁶

Schools in counties across the state are also especially short-staffed in terms of social workers, as the average was just one social worker per 14,000 students. In 26 counties, there are no social workers in schools (see Table 2). Appendix A includes tables with additional data related to student-to-mental-health-staff ratios.

³⁵ National Association of School Psychologists. (2021). *Policies addressing the shortage of school psychologists*. <https://www.nasponline.org/research-and-policy/policy-priorities/critical-policy-issues/shortage-of-school-psychologists>

³⁶ American School Counselor Association. (2021). *The role of the school counselor* [Role statement]. <https://www.schoolcounselor.org/getmedia/ee8b2e1b-d021-4575-982c-c84402cb2cd2/Role-Statement.pdf>



Table 2. Average County Student-to-Staff Ratios Statewide, Weighted by LEA Enrollment, 2018–19 School Year

Ratios and number of counties with no given staff type	Students per psychologist	Students per counselor	Students per school nurse	Students per social worker	Students per total mental health services staff
Recommended ratio (professional association)	500:1 (NASP)	250:1 (ASCA)	N/A	250:1 (NASW ³⁷)	N/A
Actual ratio	1,265:1	977:1	3,181:1	14,135:1	373:1
Number of counties with none of given staff type	7	1	7	26	0

Note: Actual ratio represents the enrollment-weighted LEA-level staffing ratio for each staff type.

It was highly uncommon for any county to meet the recommended staffing ratio. In 2018–19, only one county (Sierra County) met the NASP-recommended 500:1 ratio for students to psychologist, and only two counties (Alpine County and Mariposa County) met the ASCA-recommended 250:1 ratio of students to counselors.

The smallest LEAs, in terms of enrollment, were the most understaffed.

There was no discernable pattern of staffing ratios with any student demographic. However, the percentage of LEAs without different types of mental health staff was higher in LEAs that served fewer students (see Table 3). It is important to note that many LEAs coordinate services regionally. The lack of a psychologist in an LEA, for example, does not mean that students lack access to a psychologist.

³⁷ National Association of Social Workers. (2012). *NASW standards for school social work services*. <https://www.socialworkers.org/LinkClick.aspx?fileticket=5qpx4B6Csr0=&portalid=0>



Table 3. Percentage of LEAs Without a Psychologist, Counselor, Nurse, Social Worker, or Any of These Four Staff, by LEA Enrollment Size, 2018–19 School Year

% of LEAs without given staff	Small (< 2,500 students)	Medium (2,500 to 10,000 students)	Large (> 10,000 students)
Psychologist	66.0	3.6	1.2
Counselor	55.0	8.3	1.2
Nurse	81.1	20.2	8.1
Social worker	97.7	84.2	75.1
Mental health staff of any kind	45.4	1.2	0.0

When examined by role type, small LEAs in rural parts of the state that enrolled relatively more White students had the highest student-to-psychologist and student-to-counselor ratios. Larger LEAs in higher populated regions with more Hispanic/Latinx students were most understaffed in terms of school nurses.

Interviewees indicated that staffing shortages of both mental health and school staff have only increased since COVID. At the same time, staff are overwhelmed and overburdened, often facing secondary trauma or mental health challenges of their own. As one practitioner noted,

Adults who normally would be able to handle and support that [student] trauma are dealing with similar issues of loss and the challenge of regulating their own emotions.

Interviewee

Finding 3. School-based mental health referral pathways are not always aligned and coherent, and approaches to service delivery vary greatly across the state.

Comprehensive school-based mental health systems are evolving, with variability in the implementation of frameworks to support effective mental health referral pathways. Across practitioner discussions, it was clear that the fragmented services that vary by county, district, and provider constitute the largest barrier to effective referral pathways. While each county, district, and school has unique needs, this fragmentation makes it difficult for students to access a fully integrated, comprehensive school mental health system. In the absence of such a



system, referral pathways are not always clear or culturally responsive and often occur after opportunities for early intervention have been missed.

The whole system and structure is very cumbersome and very involved.

Interviewee

In many areas, terminology, methods, cultural values, and norms are not often shared between partnering schools and agencies, which can cause confusion, delays, and failure to coordinate services when working together. Interviewees highlighted the challenge of having mental health practitioners who are not fully integrated into the schools they serve, which has become increasingly common with staffing shortages. Without an in-depth understanding of a school and its culture, practitioners may lack the relationships needed to follow through with referrals from school staff, as they can often be seen as an unknown outsider to students and families.

If you aren't integrated in the school and are just a referral source, it is much more difficult. You don't understand the environment, there is a different dynamic when it is a sort of 'outpatient' approach.

Interviewee

Even in spaces where referral pathways have been defined and managed by a multidisciplinary, cross-agency team, staff often lack the time and resources to focus on universal (Tier 1) and targeted (Tier 2) intervention and supports. Interviewees also emphasized that most students do not need access to a licensed clinician but can benefit from supports provided by an ally, a coordinator, or school staff implementing Tier 1 and 2 supports.

Interviewees discussed the impact of stigma on access to care, with particular attention to the stigma that can come from a diagnosis that is often required to receive behavioral health services. For many students and caregivers, the stigma of a mental health diagnosis is enough to stop them from moving ahead with the referral process. Interviewees also noted the importance of delivering mental health services and supports on school campuses so that transportation is not a barrier to students accessing care.



Transportation and distance are a real thing. It might only be eight miles between two areas, but we don't have transit systems, and if people don't have a car that is really challenging.

Interviewee

In spaces with established referral pathways, practices included warm handoffs, clear guidelines for linking students to services, strong partnerships, Coordination of Services Teams, and longstanding interpersonal relationships. In fact, when asked what their county's greatest strength was in providing mental health, most interviewees discussed the strong partnerships between LEAs and community-based organizations (CBOs), as well as County Offices of Education (COEs) and Special Education Local Plan Areas (SELPA's), both through Memorandums of Understanding (MOUs) as well as informal relational connections. Many interviewees also discussed their involvement with leadership teams as well as how networks allow them to communicate regularly with other LEAs, CBOs, and colleagues throughout the state.

There has been a longstanding mentality of collaboration to figure out the best way to serve the kids and ... a willingness to engage in dialogue, discuss the reality of the situation, and collaborate.

Interviewee

There is no one way that districts approach school-based mental health. Across responses, practitioners noted that no two systems are the same, due both to demographic needs as well as to the way in which mental health services have evolved within their respective counties over time. In some areas, the county office of education is front and center in providing guidance, facilitating referral pathways, and ensuring ideas are shared across school districts on how to provide mental health services and supports to students. In other areas of the state, SELPA's took the lead in playing this role. In one county, the agency working most substantially in school-based mental health had only been founded 18 months earlier and was working tirelessly to create linkages and instill best practices across districts through innovative technical assistance. Still, in other areas, the county behavioral health department was in charge, offering both technical support as well as managing relationships with districts. Finally, the research team spoke to former CBO leaders, who worked hand in hand with districts, operating within schools, attending site staff meetings, walking the halls, and operating as members of the community; the only way a student could tell the difference between these leaders and a teacher was the logo on their shirts.



The complicated thing about California is how varied it is. Every county, county office of education, and school district has their own way of doing things.

Interviewee

Finding 4. Limited funding flexibility and varied understanding of how to navigate, maximize, and plan for sustainability of available funding sources constitute a key barrier to expanding access to mental health services for students.

Access to funding streams that support school-based mental health varies across LEAs.

Approximately half of California's LEAs participate in school-based Medicaid reimbursement programs.³⁸ Some LEAs partner with CBOs for service delivery and write these partnerships into the district Local Control and Accountability Plan (LCAP) to leverage Local Control Funding Formula (LCFF) funds. Many LEAs hire clinicians to operate between multiple school sites and draw from the general fund budget and grant dollars. Ultimately, the multiplexity of implementation approaches across LEAs depends on community needs and local agency knowledge and capacity for securing and leveraging resources to support school-based mental health services. Please refer to Appendix D for an illustration of how these various funding streams support school-based mental health services.

The variability makes it hard to figure out how to do this, some COEs hire people to go into the schools; some have MHSOAC funding while others don't; some bill Medi-Cal while some have not figured out how to do that.

Interviewee

³⁸ California Department of Education, California Department of Health Care Services, California Health and Human Services Agency, & Medi-Cal for Students Workgroup. (2021). *Medi-Cal for Students Workgroup recommendations*. California Department of Education. <https://drive.google.com/file/d/1bTQbXGen6KiBmkHPeWXLTrmlgLBLXr7Y/view>



Disparities depend on where you live and district you go to – it can really determine the services you receive, funding you can apply for, staff you can hire, etc.

Interviewee

Some school districts do not have a full understanding of existing funding systems or have capacity to leverage available funds. In small school districts where staffing is limited, it can be difficult to meet reporting, documentation, and billing requirements that have been laid out for allowable uses of funds to support school-based mental health services. Additionally, interviewees shared that important information such as funding structures or key policies such as AB 2083 are not commonly understood within LEAs and across regional partners (e.g., county agencies, service providers, CBOs), particularly in small and rural districts. As a solution, multiple interviewees had resorted to seeking technical assistance from the state, cross-county networks, or connections with fellow administrators as ways to fill in knowledge and information gaps. They also shared an interest in more formalized interregional connections and learning opportunities.

In [our] community we almost need a “Funding for Dummies,” people become overwhelmed, and growth gets stifled – people return to what they know - triage Tier 3 services. The work we need to do is all grant funded.

Interviewee

What is strange to me is that out of everybody I have talked to in [my community] not one person is familiar with AB 2083. This is the driver so that we can all work together, so it creates a huge gap in this community. Although we have patched through relationships in informal ways, countywide it is very difficult for most districts.

Interviewee

We need to create networks and know they won’t go away. ... How can we prioritize that?

Interviewee



It would be great if there was a network of consultants that could go in and help inter-agencies come together and build sustainable funding projects.

Interviewee

With the funding that is available, districts feel constrained by the law rather than supported by it. Interviewees pointed, early and often, to the dual nature of the current funding landscape in California. On one hand, resources are more robust than they have ever been before, opening up doors to new opportunities for serving students in more comprehensive ways. On the other hand, major funding streams such as Medi-Cal remain heavily restricted or carry cumbersome reporting requirements while COVID-19 recovery funds are nonrecurring and have a limited window of time in which they can be obligated. These constraints have created a dynamic in which practitioners feel they cannot use federal and state dollars to support augmenting the resource they need most—staff.

[We need] funding, resources. Both of which go hand in hand with staffing, it is a very circular problem. ... We often get stuck in silos, there is a lot of funding out there, but it is so siloed [and restricted] so now we are seeing LEAs hire their own clinicians from CBOs, robbing Peter to pay Paul, rather than coming together and figuring out how to expand supports.

Interviewee

Our state has billions of dollars, and we are still trying to figure out how to get access to services. ... Everyone is exhausted.

Interviewee

The primary issue raised with one-time funds is that they cannot be used to fund ongoing liabilities, such as full-time staff positions with benefits, because once the funding is spent or has expired, school districts will not have the resources to retain their workforce. This lack of sustainability creates a hesitancy within school districts to take action and ultimately constrains



them from providing much more than stipends, temporary programs, and other inputs that do not require multiyear commitments.

Everyone is in crisis and now has cash, but no one has the system to use it and it's going to go away. Is any of it sustainable? ... There's more stipends going out to teachers than I've seen in 25 years, which is great but not sustainable.

Interviewee

Funding sources always have to be aware of prioritizing sustainability and the ability to share between grantees.

Interviewee

We get these really robust programs but they go away when the funding goes away. When the money comes in there's always a conversation about sustainability.

Interviewee

Finding 5. A limited understanding of complex privacy laws and regulations by educational leaders and community partners can be a barrier to providing school-based mental health services.

Limited understanding of HIPAA and FERPA laws and regulations by educational leaders and community partners creates barriers to collaboration between school and community behavioral health agencies in supporting student mental health care. Interviewees suggested that additional training and tools are needed to build systemwide understanding of complex state and federal privacy laws and regulations, including how these laws intersect. Interviewees also noted that relationships between education and health agencies are critical for successful bidirectional information and data sharing and for protecting student privacy and that LEAs should invest time in establishing trusting relationships with providers and clinics.



Something we had to work out between districts and schools, was to have as inclusive an approach as possible without breaking (HIPAA/FERPA) laws. So much of it came down to trust and relationships.

Interviewee

HIPAA and FERPA are federal laws that determine who can share what information with whom and in what situations. California also has state laws that address confidentiality and disclosure of health and education information. According to a joint publication by the U.S. Department of Health and U.S. Department of Education, “a school health program’s records are subject to FERPA if the program is funded, administered and operated by or on behalf of a school or educational institution.”³⁹ According to the California School-Based Health Alliance, “a school health program’s records are subject to HIPAA if the program is funded, administered and operated by or on behalf of a public or private health, social services, or other non-educational agency or individual.”⁴⁰ The rules that apply can impact school-based mental health referrals, interagency collaboration, health care billing, and access to mental health services for students.

When providing mental health services to students on campus, an LEA must determine whether the information and records maintained related to those services are governed by FERPA or HIPAA, who should sign release forms to share information across agencies, and whether all associated paperwork meets applicable legal requirements. Interviewees suggested that LEAs must first answer the following three questions to make these determinations:

- Where is the funding coming from?
- What are the tools and services to be provided and who is providing them?
- Who is operating and administering the program?

District legal counsel should then provide guidance on whether the activities are governed under HIPAA or FERPA. An analysis of the Confidentiality of Medical Information Act must also

³⁹ U.S. Department of Health and Human Services & U.S. Department of Education. (2019). *Joint guidance on the application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to student health records*. https://studentprivacy.ed.gov/sites/default/files/resource_document/file/2019%20HIPAA%20FERPA%20Joint%20Guidance%20508.pdf

⁴⁰ California School-Based Health Alliance. (n.d.). *A California guide for sharing student health and education information*. <https://www.schoolhealthcenters.org/resources/sbhc-operations/student-records-consent-and-confidentiality/california-guide/>



take place, as well as application of any laws pertaining to remote service if that is being provided.⁴¹

There are many LEA partnership models for mental health service delivery. Depending on the partnership arrangement, models may operate under different privacy and information sharing rules and require different policies, procedures, and paperwork. Below are sample scenarios developed by Breaking Barriers and the National Center for Youth Law that illustrate common partnership models that require different information sharing structures:

- **Scenario 1:** County mental health plan employees provide mental health consultation to teachers and treatment to students on a school site through a contract with the school district. County employees are funded by the county mental health plan. Students are referred by school district staff.
- **Scenario 2:** The school district funds a wellness center on a school site. Services are provided to special education students and general education students by school district staff counselors and psychologists as well as by marriage and family therapists and licensed clinical social workers from a community-based organization. Services are funded by the school district through employees and contracts with CBOs. Students are referred by school district staff.
- **Scenario 3:** The county mental health plan funds a school district to provide mental health plan services on school campuses to eligible students. Employees are hired by the school district and are funded through a contract with the mental health plan. Services are provided on campus.
- **Scenario 4:** The district contracts with a private health care agency to provide telehealth mental health services to students. The telehealth provider does initial screens and acute services and refers students to other community-based supports when longer term services are recommended. School nurses, counselors, and staff set up urgent care visits with the private health care provider to do mental health screenings and services for students.

⁴¹ Gudeman, R. (2018). *HIPAA or FERPA? A primer on sharing school health information in California, 2nd ed.* National Center for Youth Law. <https://youthlaw.org/publication/hipaa-or-ferpa-a-primer-on-sharing-school-health-information-in-california-2nd-edition/>



Considerations

The following considerations emerged from the preliminary landscape analysis:

Consideration 1. Invest in diversifying, recruiting, training, and retaining a behavioral and mental health workforce that is representative of California’s linguistically and culturally diverse population.

This includes pupil personnel service staff and community behavioral health partners that understand educational systems and effective approaches to integrated delivery of mental health services in school communities. Across the state, mental health staffing is below the ratios recommended by professional organizations. The analysis of CDE pupil services staff data revealed that in Alpine County, Lassen County, Modoc County, Mono County, Trinity County, Tuolumne County, and Yuba County, there are no psychologists, nurses, or social workers employed by LEAs countywide.⁴²

The smallest LEAs in terms of enrollment were the most understaffed. Counties may consider different strategies to pool and distribute mental health staff to address understaffing, especially in small LEAs. State, regional, and community partners may offer supports to supplement and support county and LEA efforts to employ more mental health staff.

Consideration 2. Provide ongoing cross-agency technical assistance focused on building capacity and supporting the continuous improvement of comprehensive and cohesive, multi-tiered school-based mental health service delivery systems that are codesigned with students and families.

Technical assistance and training may include the following:

- guidance and tools to help districts and schools leverage their existing MTSS and established implementation structures to support a continuum of evidence-informed and culturally responsive school mental health services within one cohesive multi-tiered system designed to support the whole person, including strategies to facilitate buy-in from key community partners and messaging to key audiences
- guidance and tools to inform the development of mental health referral pathways and ongoing technical assistance to support their implementation in ways that mitigate

⁴² In these counties, COEs often employ psychologists, nurses, and social workers who provide services to LEAs within the county.



biases, are culturally responsive, and center students and families at each step of the process from identification to accessing supports and services; this includes the use of outcome and fidelity data to monitor the progressive impact of specific interventions and services, as well as ongoing evaluation of the comprehensive mental health system and referral pathways

- training and supports that include implementation of data practices and procedures for problem-solving and data-based decision-making using multi-informant, measure, and source information and universal social, emotional, and behavioral health screening for matching students to interventions at each tier of the service delivery
- ongoing training to all members of school communities on how to support the mental health and well-being of young people and adults and that includes recognizing signs and symptoms of mental health needs and how to connect individuals to behavioral and mental health services
- continued support for the health and well-being of school communities through family engagement, comprehensive mental health promotion, and other universal approaches, such as trauma-informed practices, social-emotional learning, and positive school climate

This effort may begin with expanding the CDE's capacity to support coordinated and systematic statewide implementation of technical assistance, including a state-level, cross-agency, multidisciplinary leadership team that makes shared, data-informed decisions to monitor, problem-solve, and inform the continuous improvement of statewide technical assistance and support to local agencies. Building state capacity would provide the requisite infrastructure to match technical assistance to the unique strengths, needs, and resources of each school community and leverage opportunities to scale initiatives and build capacity in communities with the highest need for mental health services and supports through continuous improvement using multiple data sources, such as the [CalSCHLS Query tool](#).⁴³

Consideration 3. Create structures that support more sustainable, straightforward use of funds to expand and continuously improve comprehensive school-based mental health systems.

- Support technical assistance and training at all levels (school, district, county) of the service delivery system on how to leverage Medicaid and other allowable funds to support mental health services within schools.

⁴³ WestEd. (2022). *Query CalSCHLS*. California Department of Education.
<https://calschls.org/reports-data/query-calschls/>



- Invest in increasing consistent, long-term funding guarantees to support school-based mental health services and supports, particularly through state funds such as the LCFF, such that staffing can be augmented at the district level and long-term partnerships can be established between districts and CBOs.
- Provide accountability structures to ensure that funds are used for their intended purpose to support school-based mental health services and supports. This may include the introduction of new regulatory structures that promote the successful implementation of mental health referral pathways and that set expectations for improving mental health outcomes for students within school district LCAPs.

Consideration 4. Support the development of tools and training for local educational agencies (LEAs) and partner organizations on appropriate cross-agency information sharing related to student mental health services and supports; this information sharing should prioritize student and family privacy.

- Conduct a scan of existing tools and guidance for LEAs and partner organizations on HIPAA and FERPA. Develop additional tools for field use as determined necessary, including HIPAA and FERPA decision tree tools as well as model forms, procedures, and protocols to support implementation of privacy laws and regulations.
- Provide ongoing training opportunities for LEAs, providers, and partner organizations on tools, forms, procedures, and protocols to support implementation of privacy laws and regulations.
- Adopt policies to allow for information sharing between LEAs and providers to help track student mental health services and supports.



Limitations and Future Directions

Particular caution is warranted when considering the implications of these findings. Given the scope of this analysis, the research team was only able to capture a glimpse of California's current mental health referral pathway landscape to inform the complex systems change needed to build capacity and sustain effective behavioral and mental health referral pathways. The greatest limitation of this landscape analysis is that the sample of interviewees was too small and not necessarily representative of role types across the state to make generalizations. Furthermore, the sample was limited to district administrators, county leaders, and statewide consultants and experts, while referral pathways are realized at the school and community level. **Future studies would benefit from a more robust and diverse sample of interviewees that includes students, families, educators, community partners, providers, and multidisciplinary teams implementing and/or accessing a school community's continuum of mental health and related supports.** In future studies, targeted surveys may provide an efficient means for gathering information from multiple subgroups on how referral pathways are being implemented as well as the facilitators and barriers to effective and culturally responsive services. In addition to learning from school communities that have established comprehensive mental health systems, insights from underserved populations and underresourced (e.g., rural) communities may provide a better understanding of the structural and systemic barriers and uncover innovative approaches to circumventing these barriers.

CHKS data used in the quantitative analysis primarily came from larger LEAs, so the responses from this survey may not be representative of the whole state. As previously noted, most of the responses were from students in urban LEAs with larger student enrollment sizes. Accordingly, the results may be skewed toward larger, more urban LEAs. Furthermore, because the survey is voluntary and asks students about sensitive topics, student response rates at each LEA were variable. It is unclear in what way these factors bias the responses, if at all. While the issues presented by the voluntary nature of the survey are unavoidable, in the future researchers could merge multiple years of CHKS data to ensure more counties, LEAs, and students are represented in the analysis. This analysis also included only a subset of items focused primarily on indicators of behavioral and mental health risk factors and from the student (self-report) version of the survey. Future analyses would benefit from including parent and staff reports as well as modules and/or items that focus on social and emotional well-being and other factors supporting the mental health of school communities, such as school climate.



Other publicly available data sources may also better explain the complete landscape of mental health professionals serving California’s students, families, and educators and how innovations such as telehealth have impacted service delivery. Furthermore, staffing ratios may not always be the best proxy for service delivery. For instance, if an LEA does not employ a psychologist, that does not necessarily mean students lack access to a psychologist. The staffing ratio data used in this study do not contain counts of Full-Time Equivalent (FTE) staff; rather, they contain only head counts. These head counts may not speak to the true extent that an LEA is over- or understaffed. Further, the presence of school-based mental health staff does not necessarily speak to the quality or quantity of mental health services or supports. A future analysis could measure the number of mental health services provided to students, perhaps using Medi-Cal claims data, and utilize FTE head counts to more rigorously analyze gaps in mental health services. Finally, each quantitative data source was taken from the 2018–19 school year, and because of the COVID-19 pandemic, there may be reasons to believe many aspects of the data have changed. This warrants further investigation into how the emotions and behavior of students have changed and are changing during the pandemic and how LEAs are responding to the changing needs and contexts of their school communities. Prepandemic, between 5 percent and 13 percent of students statewide reported missing school related to mental health concerns. Given the negative outcomes associated with chronic absenteeism,⁴⁴ this is an important indicator to continue to track at the school, district, and county levels with more recent data collected during the pandemic. Future analyses should incorporate more data and unpack trends over time to understand the association between the pandemic, the mental health system, and the mental health of California students.

A more comprehensive landscape analysis of the referral pathways within the networks of community partners across the state could provide valuable information for informing the technical assistance and support for implementing more robust and equitable referral pathways to accessing effective services.

⁴⁴ Chang, H. N., Bauer, L., & Byrnes, V. (2018). *Data matters: Using chronic absence to accelerate action for student success*. Attendance Works and Everyone Graduates Center.
<http://www.attendanceworks.org/data-matters/>



Conclusion

California is facing an unprecedented opportunity to increase the state's capacity for supporting student mental health and well-being and for ensuring students, families, and educators have the opportunity to thrive socially and emotionally. School-based mental health referral pathways provide the through line to comprehensive school-based mental health systems and how students, families, and educators can access equitable and effective mental health supports within their school communities. While this initial landscape analysis is not all-encompassing, it provides an initial glimpse into the many facets of the state's developing comprehensive school-based mental health service delivery system.

Appendices

Appendix A

Table A1. Student Demographic Information for the Counties With Highest Student-to-Psychologist Ratios

County name	Students per psychologist	Total enrollment	% Black students	% Hispanic/ Latinx students	% White students	% Unduplicated pupils
Calaveras County	4,835	4,835	0.4	20.5	70.3	53.4
Glenn County	4,644	4,644	0.4	62.8	29.8	75.5
Siskiyou County	3,058	3,058	1.6	17.5	65.1	57.0
Inyo County	2,528	2,528	0.6	38.8	35.3	57.2
Plumas County	2,187	2,187	1.0	16.4	72.4	44.1
Statewide Average	1,265	6,425	5.3	54.6	22.8	60.4

Table A2. Student Demographic Information for the Counties With Highest Student-to-Counselor Ratios

County name	Students per counselor	Total enrollment	% Black students	% Hispanic/ Latinx students	% White students	% Unduplicated pupils
Trinity County	1,350	1,350	0.2	10.4	67.8	63.5
Plumas County	1,094	2,187	1.0	16.4	72.4	44.1
Yuba County	942	14,129	3.5	38.4	41.3	66.1
Santa Cruz County	919	38,607	0.8	56.5	34.9	51.7
San Benito County	917	11,004	0.4	76.1	18.8	60.4
Statewide Average	997	6,425	5.3	54.6	22.8	60.4

Table A3. Selected Student Demographic Information and Staffing Data by LEA Size, 2018–19 school year*

Percentage in question	Small (<2,500)	Medium (2,500 to 10,000)	Large (> 10,000)
% Black	1.8	3.2	6.3
% American Indian/Native American	2.1	0.5	0.3
% Asian	3.7	8.4	10.2
% Filipino	0.8	2.3	2.6
% Hispanic/Latinx	43.8	51.7	56.4
% Students of more than one race	4.2	4.1	3.4
% Pacific Islander	0.3	0.4	0.5
% White	42.2	28.3	19.5
% No race reported	1.1	1.1	0.8
% English Learners	17.0	20.2	19.3
% in foster care	0.5	0.5	0.5
% Unhoused	2.9	3.2	3.5
% Migratory	1.9	1.3	0.5
% Students with an IEP	10.5	11.0	11.8
% Socioeconomically disadvantaged	57.6	54.7	63.0
% Unduplicated pupil count	60.5	58.5	65.5
% LEAs with no psychologist	66.0	3.6	1.2
% LEAs with no counselor	55.0	8.3	1.2
% LEAs with no nurse	81.1	20.2	8.1
% LEAs with no social worker	97.7	84.2	75.1
% LEAs with none of any MH staff	45.4	1.2	0.0

*Note: Staffing shortages depicted by these data alone may not necessarily translate to a lack of access to mental health professionals at schools. Districts often collaborate within and across regions to more efficiently serve their students, particularly in regions with the fewest mental health staff per student.



CHKS Student Mental Health Indicators Analyzed by the Research Team⁴⁵

Percent of students who missed a day of school in the last 30 days for any of the following reasons:

- They were being bullied or mistreated at school
- They felt sad, hopeless, anxious, stressed or angry
- They didn't feel safe at school or going to and from school
- They used alcohol or drugs

Percent of students who, more than once during the last 30 days, used the following substances:

- Cigarettes, smokeless tobacco, e-cigarettes or other vaping devices
- Alcohol (one or more drinks)
- Alcohol (five or more drinks in a couple of hours)
- Marijuana (whether smoked, vaped, eaten, or drank)

Percent of students who indicated that the following statements were pretty much true or very much true:

- "I feel happy at school"
- "I feel safe at school"
- "At my school, there is a teacher or some other adult who really cares about me"

⁴⁵ California Department of Education. (2021). *California Healthy Kids Survey*. Obtained through submission of a data sharing agreement with the California Department of Education.

Appendix B

Note: The protocol below was adapted to create versions for interviews with staff from behavioral health organizations and consultants/advocates. The areas of focus were the same, but questions were tailored to the unique settings and roles of the interviewees. Copies of all versions of our interview protocols are available upon request.

CA Mental Health Referral Network and Pathway Landscape Analysis Interview Protocol

School District Version

Introduction

Thank you for agreeing to talk with us about your school district's procedures and policies for linking students, families, and educators to social, emotional, and behavioral health services and supports, including substance abuse recovery programs. My name is _____, and I work for the Region 15 Comprehensive Center at WestEd, a federally funded center responsible for providing capacity-building technical assistance to SEAs, including California, Nevada, Utah, and Arizona. I am joined by my colleague, _____, who also works for the R15 CC and will be helping to capture today's conversation.

We are conducting a preliminary landscape analysis in partnership with the California Department of Education (CDE) and State Board of Education (SBE) to identify the characteristics of referral networks and pathways within California schools and partnering behavioral health organizations.

We recognize that districts and/or schools are at various stages of implementing comprehensive, multi-tiered school mental health support systems. We are interested in learning more about your district's process for identifying, referring, assessing, and matching students, families, and educators to appropriate services, resources, and supports within a school and/or larger school community. The aim of this conversation is in no way intended to be evaluative, but rather for us to learn about

- the continuum of mental health supports and services available to your students, families, and educators;
- the systems and partnerships within your district's schools and community to link students, families, and educators to appropriate and effective mental health services; and



- how to better understand the barriers and enablers to building culturally responsive and sustainable referral pathways.

A note on confidentiality: This information will be used in an internal report for the CDE and the SBE summarizing the findings of this preliminary landscape analysis. We will only share information specific to your district in the report with your permission, and we will not use your name.

We have planned this interview to last no longer than 1 hour. To ensure we complete the interview within this time frame, we may push the conversation ahead to ensure we can complete our line of questioning. Notes will be taken during the interview by a Region 15 CC staff person. The interview will not be audio recorded. Are you okay with this?

Interview Information

Date: [add date]

R15 CC Staff:

Interviewer: [first, last]

Notetaker: [first, last]

School District: [name]

Interviewees and Roles:

Name: _____

Role: _____

Name: _____

Role: _____

Name: _____

Role: _____

Name: _____

Role: _____

Name: _____

Role: _____

Questions

This interview is voluntary. Please let us know if you would like to skip a question or no longer continue with the interview. We would also like to note that this interview protocol was developed for a diverse set of interviewees, and some questions may not pertain to your role and/or expertise.



Strengths and Needs

- What are some of the key resources, strengths, and assets of your school community that support the mental health and well-being of the students, families, and educators?
- What are the primary mental health needs of your community?
- What inequities/gaps in access to acceptable and effective mental health supports and services exist in your school communities?
 - Probe: How are these inequities being addressed?
- What are the greatest barriers to students, families, and educators accessing needed mental health supports?

Leadership

- Who leads your school mental health system and/or initiatives?
- Is there a leadership team?
 - Probe: If so, who are the members of the team?
- Does your leadership team include community partners, youth, and/or family members?
 - Probe: How are these roles supported?

Partnerships

- Which mental/behavioral health or related (e.g., family advocates, housing, after school programs, etc.) organizations does your district partner with?
 - Probe: What are the roles of your community partners?
 - Probe: How are roles and responsibilities of community partners defined (e.g., MOU, MOA, etc.)?
- Are you familiar with AB 2083? If so, how are these partnerships supporting the referral process?

Foundation, Framework, or Model

- What initiatives are you implementing to support the mental health and well-being of all students, families, and educators in your school community?
- Which framework/s or service delivery model/s focused on comprehensive school-based mental health is your district implementing (e.g., MTSS, ISF, Community Schools, SOC, etc.)?
 - Probe: How well is the framework/model being implemented (e.g., length of initiative, barriers/enablers, fidelity data)?



Decision-Making/Referral Processes and Procedures

- What types of social, emotional, and behavioral data do your school teams use to make decisions about mental health and social-emotional supports and services?

Does your district have decision rules for early identification, screening, progress monitoring, and fading mental health supports and services?

- How are you monitoring implementation fidelity of interventions and your system/model?
- What procedures and processes are in place to ensure effective identification and intervention practices are culturally responsive and sustaining?
- How are you facilitating and coordinating care with community partners?
 - Probe: Once referred, how do you know if the student/family/educator accessed supports? Is there a warm handoff?
 - Probe: How is the effectiveness of interventions provided by all partners monitored?
 - Probe: What procedures and processes are in place for collaborative decision-making that centers students and families?

Data Systems and Sharing

- What are your procedures for managing referral flow within your schools and to community partners?
- How are you sharing information with community partners?
- Do HIPAA and FERPA regulations hinder sharing information with community partners? How?
- What type of student record management system/s are you using?
- Does data sharing with community partners include progress monitoring, outcome, and fidelity data?

Funding and Policies

- How are school mental health services funded in your school community?
- Are you accessing Medi-Cal funding?
 - Prompt: If yes, which model/s (LEA, CBO, SELPA, COE, CHA) and what services are supported through that funding?
 - Prompt: If no, why not?



- What strategies are you using to ensure that students eligible for Medicaid are accessing needed mental health supports?
- How are district, state, and federal policies, regulations, and funding supporting your efforts to meet the mental health and wellness needs of your school community?
- How are district, state, and federal policies, regulations, and funding creating barriers for your efforts to meet the mental health and wellness needs of your school community?

COVID

- How has the pandemic impacted mental health service delivery in your school communities, including collaboration with your community partners?
- Have telehealth opportunities been made more available?
 - Probe: How have telehealth opportunities been received by providers, students, families, and educators?

Closing/Final Question

- What are two or three things that would have the biggest impact on improving access to mental health supports and services in your district?

Thank you!

Post Interview Comments and/or Observations

[add comments and observations]



Appendix C

Additional Resources

Funding

[Medi-Cal for Students Workgroup Recommendations](#)

[Practical Guide for Financing Social, Emotional, and Mental Health in Schools](#)

[Public Funding for School-Based Mental Health Programs](#)

[School Mental Health 101: A Primer for Medi-Cal Managed Care Plans](#)

[School Mental Health Quality Guide: Funding and Sustainability](#)

HIPAA/FERPA

[HIPAA and FERPA Laws: A School Mental Health Navigation Tool for Pacific Southwest States of Hawaii, California, Nevada, and Arizona](#)

[HIPAA or FERPA? A Primer on Sharing School Health Information in California](#)

[HIPAA, FERPA, Both or Neither? A Flowchart for Decision-Making](#)

[Joint Guidance on the Application of the Family Educational Rights and Privacy Act \(FERPA\) and the Health Insurance Portability and Accountability Act of 1996 \(HIPAA\) to Student Health Records](#)

[Guide for Sharing Student Health and Education Information](#)

MTSS/Whole-Person Models and Frameworks

[Advancing Comprehensive School Mental Health Systems: Guidance from the Field](#)

[Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide PBIS, Volume 2: An Implementation Guide](#)

[Advocating for Comprehensive School Mental Health: A Tip Sheet for Decision Makers](#)

[Fostering the Whole Child: A Guide to School-Based Mental Health Professionals](#)

[Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs](#)



Referral Pathways

[Coordination of Services Team Guide](#)

[CSHA's Connecting Students to Mental Health Services: Creative Collaborations, Funding, & Evidence-Based Practices](#)

[School Mental Health Referral Pathways \(SMHRP\) Toolkit](#)

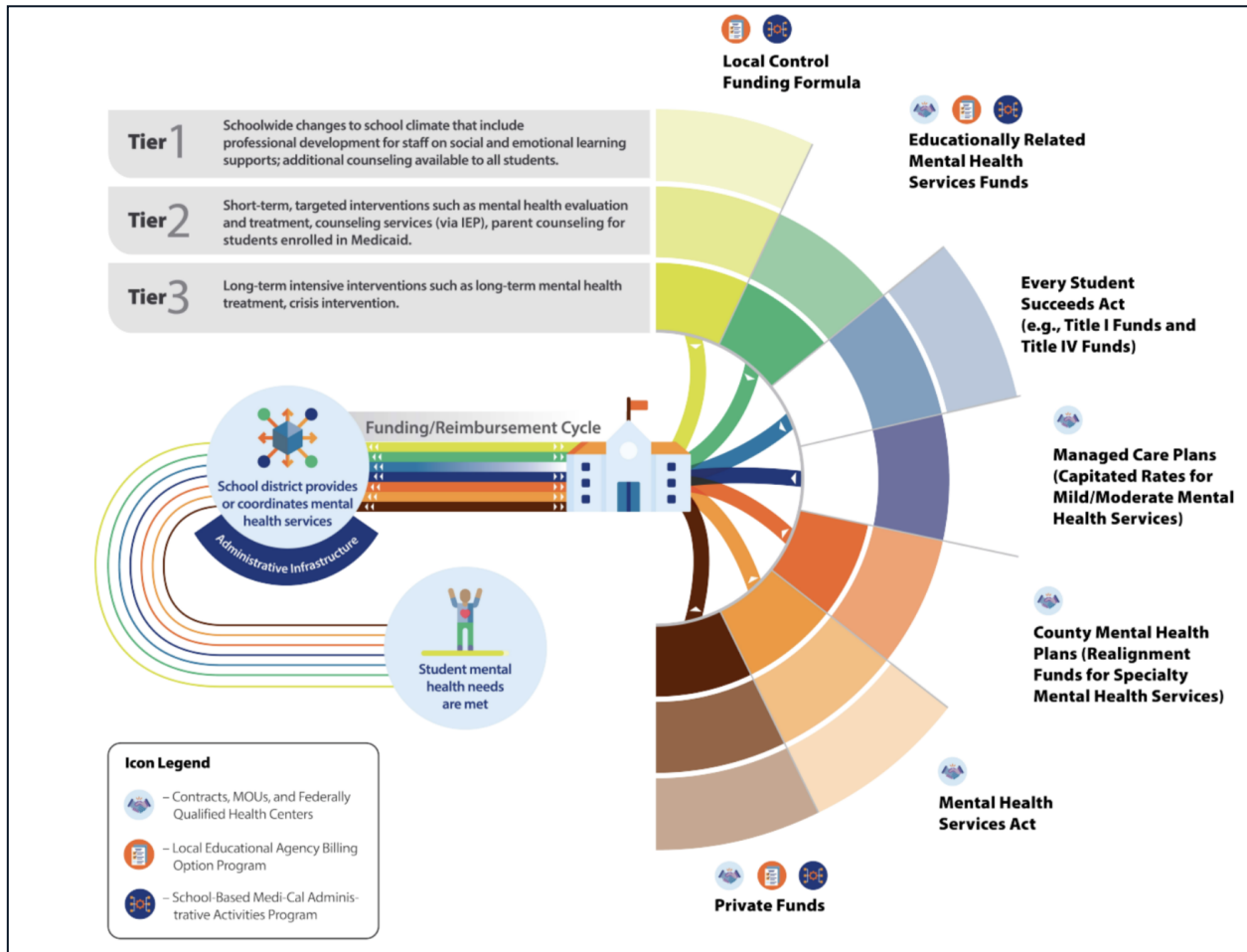
Universal Screening

[Best Practices in Universal Screening for Social, Emotional, and Behavioral Outcomes: An Implementation Guide](#)

[School Mental Health Quality Guide: Screening](#)

Appendix D

School-Based Mental Health Funding Sources⁴⁶



Descriptive Text: School-Based Mental Health Funding Sources Figure Full Description

Overview:

A graphic showing a circular MTSS framework with a child at the center. Around the child are lines representing seven federal and state funding sources, and for each funding source the graphic shows whether and at which tier in the system it can be used to fund a continuum of mental health services to support the child. Arrows illustrate the flow of funding into the

⁴⁶ California Department of Education, California Department of Health Care Services, California Health and Human Services Agency, & Medi-Cal for Students Workgroup. (2021). *Medi-Cal for Students Workgroup recommendations*. California Department of Education. <https://drive.google.com/file/d/1bTQbXGen6KiBmkHPeWXLTrmlgLBLXr7Y/view>

school, back out to pay for mental health services, and back in through Medicaid reimbursement programs.

Tier 1:

This tier consists of schoolwide changes to school climate that include professional development for staff on social and emotional learning supports and additional counseling available to all students. Federal and state funding sources include the following:

- Local Control Funding Formula
 - Medi-Cal programs and/or partnerships include the following:
 - Local Educational Agency Billing Option Program
 - School-Based Medi-Cal Administrative Activities Program
- Every Student Succeeds Act (e.g., Title I Funds and Title IV Funds)
 - Medi-Cal programs and/or partnerships include the following:
 - None
- Mental Health Services Act
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
- Private Funds
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
 - Local Educational Agency Billing Option Program
 - School-Based Medi-Cal Administrative Activities Program

Tier 2:

This tier contains short-term, targeted interventions such as mental health evaluation and treatment, counseling services (via IEP), and parent counseling for students enrolled in Medicaid. Federal and state funding sources include the following:

- Local Control Funding Formula
 - Medi-Cal programs and/or partnerships include the following:
 - Local Educational Agency Billing Option Program
 - School-Based Medi-Cal Administrative Activities Program



- Educationally Related Mental Health Services Funds
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
 - Local Educational Agency Billing Option Program
 - School-Based Medi-Cal Administrative Activities Program
- Every Student Succeeds Act (e.g., Title I Funds and Title IV Funds)
 - Medi-Cal programs and/or partnerships include the following:
 - None
- Managed Care Plans (Capitated Rates for Mild/Moderate Mental Health Services)
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
- County Mental Health Plans (Realignment Funds for Specialty Mental Health Services)
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
- Mental Health Services Act
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
- Private Funds
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
 - Local Educational Agency Billing Option Program
 - School-Based Medi-Cal Administrative Activities Program

Tier 3:

These are long-term, intensive interventions such as long-term mental health treatment and crisis intervention. Federal and state funding sources include the following:

- Local Control Funding Formula
 - Medi-Cal programs and/or partnerships include the following:
 - Local Educational Agency Billing Option Program
 - School-Based Medi-Cal Administrative Activities Program



- Educationally Related Mental Health Services Funds
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
 - Local Educational Agency Billing Option Program
 - School-Based Medi-Cal Administrative Activities Program
- County Mental Health Plans (Realignment Funds for Specialty Mental Health Services)
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
- Mental Health Services Act
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
- Private Funds
 - Medi-Cal programs and/or partnerships include the following:
 - Contracts, MOUs, and Federally Qualified Health Centers
 - Local Educational Agency Billing Option Program
 - School-Based Medi-Cal Administrative Activities Program

The figure illustrates the “Funding/Reimbursement Cycle” by showing how each tier of funding sources flows into schools, back out to pay for mental health services, and back in through Medicaid reimbursement programs. School districts provide or coordinate mental health services via an administrative infrastructure. Ultimately, the mental health needs of all students are met with this system.

